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**Notice of Independent Review Decision**

**DATE OF REVIEW:** February 12, 2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Voltaren 1%, 30 day supply, 1 refill.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**
M.D., Board Certified in Physical Medicine and Rehabilitation with Sub-specialty Certification in Pain Medicine.

**REVIEW OUTCOME**
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒**Upheld** **(Agree)**

☐Overturned (Disagree)

☐Partially Overturned (Agree in part/Disagree in part)

I have determined that the requested Voltaren 1%, 30 day supply, 1 refill is not medically necessary for the treatment of the patient's medical condition.

**PATIENT CLINICAL HISTORY [SUMMARY]:**
The patient is a female with a history of shoulder pain. The submitted documentation indicates that the patient is status post shoulder surgery in February 2014. A letter of medical necessity was submitted on 12/23/14 for Voltaren gel 1%. It was noted that the patient was unable to take certain pain medications while flying, as she is a flight attendant and must be able to perform her duties. The patient has also had complications due to the amount of oral nonsteroidal anti-inflammatory drugs (NSAIDs) she has taken for the pain. A request has been submitted for Voltaren 1%, 30 day supply, 1 refill.

The URA indicates that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested medication. Specifically, the initial denial noted that this medication has not been evaluated for the treatment of spine, hip or shoulder pathology. Additionally, the URA noted

that there is no indication of what types of problems with patient had with the use of oral anti-inflammatory medications. On appeal, the URA noted that no pertinent clinical information was provided as to why a gel would be preferable over oral Voltaren or some other application. Additionally, the URA indicated that oral NSAIDs have not been tried beyond ibuprofen and Naproxen, prior to resorting to a gel.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

Per ODG criteria, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Voltaren gel 1% is indicated for the relief of osteoarthritis pain in a joint that lends itself to topical treatment. This is noted to include the ankle, elbow, foot, hand, knee, and wrist. While it is noted that the patient has experienced gastrointestinal issues with oral nonsteroidal anti-inflammatory drugs (NSAIDs), the patient maintains a diagnosis of pain in a joint of the shoulder region. Voltaren gel 1% is not indicated for this condition. Additionally, it has not been evaluated for treatment of the shoulder. Therefore, the requested medication is not medically indicated in this patient's case. Thus, Voltaren 1%, 30 day supply, 1 refill is not medically necessary for the treatment is this patient.

Therefore, I have determined the requested Voltaren 1%, 30 day supply, 1 refill is not medically necessary for treatment of the patient's medical condition.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☐ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**